July
07

UTAH COMPREHENSIVE HEALTH INSURANCE POOL

outline of coverage

HIPUtah
Utah Comprehensive Health Insurance Pool

PRODUCER REFERRAL FEE

HIPUtah is offering a one-time $50 referral fee to Producers, who help an individual complete an application for the HIPUtah program. The referral fee will be paid after the new enrollee's first premium payment is processed by SelectHealth.

The Producer section of the application must be completed in order to receive the referral fee. The Utah Insurance Department will verify the Insurance License Number provided on the application, send payment directly to the Producer and issue a 1099 at year end.

Please note that payment can only be made to an individual Producer, not an agency.

The Utah Comprehensive Health Insurance Pool (HIPUtah)

In 1991, the state established the Utah Comprehensive Health Insurance Pool (HIPUtah) to specifically address the problem of people with serious medical conditions, such as cancer, diabetes, heart disease, and other chronic illnesses that made them unable to obtain health insurance at any price.

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Coverage in HIPUtah is not guaranteed. Each application will be carefully reviewed to assure that all eligibility requirements are met. If an applicant is eligible for coverage in the private market, he or she is not eligible for HIPUtah, unless HIPAA (the Federal Health Insurance Portability and Accountability Act of 1996) eligible.

The benefits and features of HIPUtah are described briefly in this document. This document is not an insurance policy, and the information provided is governed by the specific terms and conditions of the HIPUtah Enrollee Agreement issued to enrollees.

If you have any questions about the information in this packet, please call 801-442-6660 (Salt Lake Area) or 800-705-9173.

Plan Options

HIPUtah offers three standard Health Maintenance Organization (HMO)-type products and a High Deductible Health Plan (HDHP), which is designed to be used with a Health Savings Account (HSA). The HDHP plan uses the same provider and facility network and covers the same medical services. The major differences between these plan options are outlined below.

HMO

- Medical deductible options are $500, $1,000, and $2,500
- Once the deductibles are met, enrollees are responsible for 20% coinsurance for covered medical services
- Separate pharmacy deductibles apply ($150, $250, and $500) with each of these plan options

HDHP

- The deductible is $5,000
- One deductible applies to both medical and pharmacy
- The entire deductible must be met before any benefits are paid with the exception of preventive care services
- This plan option is designed for use with an HSA if you choose; an HSA can save money tax free for qualified medical expenses

NOTE: *If you choose to set up an individual HSA, it is your responsibility to do so through a financial institution. Please be aware that HIPUtah has no involvement with HSAs.*

IMPORTANT: *Enrollees can only switch to higher deductible plan options. In other words, once you enroll on the HDHP plan, you cannot switch to a lower deductible plan option.*

Eligibility

WHO IS ELIGIBLE?

A person is eligible for HIPUtah coverage if he or she meets the following criteria:

1. Has resided in Utah for 12 consecutive months immediately preceding the date of application for HIPUtah (the 12 month requirement can be waived if moving from another state's high risk pool);
2. Pays the established premium;
3. Meets the required health underwriting criteria established by the State of Utah; and
4. Does not fall into the ineligible categories listed later in this outline.

OR

A person is eligible for HIPUtah coverage if he or she pays the established premium and meets the following criteria:

1. Is HIPAA eligible and has at least 18 months of prior coverage, the most recent prior coverage being under a group health plan, government plan or church plan, and has elected and exhausted COBRA or state continuation plan where available;
2. Applies for HIPUtah coverage within 63 days of termination from prior coverage; and
3. Does not fall into the ineligible categories listed later in this outline.

WHO IS NOT ELIGIBLE?

A person is not eligible for HIPUtah coverage if any one of the following is true:

1. The person is eligible for benefits under Medicaid or Medicare except for a person who has a spend down as provided in Utah Code Ann. §31A-29-112;
2. HIPUtah coverage has been terminated within the last 12 months unless the person demonstrates that continuous other coverage has been involuntarily terminated for any reason other than nonpayment of premium, unless the person is HIPAA eligible;
3. The person has exhausted the maximum lifetime benefits offered by HIPUtah;
4. The person is an inmate of a public institution;
5. The person is eligible for a public health plan through which medical care is provided;
6. The person is eligible for group health insurance through an employer plan;
7. The person has coverage substantially equivalent to HIPUtah coverage either as an insured or covered dependent or would be eligible for substantially equivalent coverage if the person elected to obtain such coverage;
8. The person's health condition does not meet the health underwriting criteria established by the State of Utah, unless the person is HIPAA eligible; or
9. The person has not resided in Utah for 12 consecutive months, unless HIPAA eligible.
10. The person's employer pays any part of the individual's health insurance premium, either as an insured or a dependent, for pool coverage.

Are You HIPAA Eligible?

Under a federal law known as HIPAA, which stands for the Health Insurance Portability and Accountability Act, if you are an "eligible individual" who has recently lost their employer- or union-sponsored group health plan, you have a right to purchase individual health coverage through HIPUtah, without a preexisting condition exclusion.

In order to be HIPAA eligible, all of the following must apply:

- Your last healthcare coverage must have been under a group plan, governmental plan, or church plan, including COBRA or state continuation coverage, for an aggregate of at least 18 months during which there was no break of 63 or more complete days in a row. This prior health coverage is referred to as "creditable coverage."
- You are not eligible under a group health plan, Medicare, Medicaid, and/or do not have other health insurance coverage.
- You did not lose your latest health coverage due to nonpayment of premium or fraud.
- If you qualify for COBRA or state continuation coverage, you must accept the coverage and continue the coverage for the maximum time period allowed. Note: When an employer terminates its group health plan entirely, COBRA coverage ends and is considered exhausted.

Once COBRA or state continuation coverage has been exhausted, you have 63 days to file an application to get a policy through HIPUtah as a HIPAA eligible individual. If you accept a conversion policy or a short-term policy after exhausting COBRA, you give up your HIPAA eligibility. It is important to know that a conversion policy is not a HIPAA policy.

When applying for the high-risk pool you can present a Certificate of Creditable Coverage from your insurance company or health plan showing that you have a total of 18 months of creditable coverage as part of applying for coverage under HIPUtah. If a Certificate of Creditable Coverage is not available, you may document your prior health coverage by other means, including by telephone.

Just remember, if you are interested in obtaining individual coverage and you meet the other criteria to be an eligible individual, you should apply for this coverage as soon as possible to avoid losing your eligible individual status due to a 63-day break.

Coverage Guidelines

The following guidelines apply to the HIPUtah Plan:

HIPUTAH PROVIDER NETWORK

The HIPUtah Provider Network is comprised of the Select Care℠ network and the University of Utah (U of U) providers, facilities, and pharmacies. For the most current HIPUtah Provider & Facility Directory, visit www.selecthealth.org.

Enrollees must always use participating providers; otherwise, services will not be covered. An exception is emergency services obtained from the closest available facility (including out of state), regardless of whether that facility is under contract with the HIPUtah network. SelectHealth reserves the right to review all emergency claims to determine whether such claims satisfy the requirements for emergency services.

MANAGED CARE

HIPUtah will apply a care management program, which helps ensure that services enrollees receive are medically necessary, appropriate, and consistent with current medical practice. The program has three methods of reviewing the healthcare received: prenotification, precertification, and case management. It is the enrollee's responsibility to verify prenotification/precertification is obtained by a provider.

WHAT IS NOT COVERED

The following is a brief summary of expenses not eligible for coverage by HIPUtah. The HIPUtah Enrollee Agreement contains a complete list of exclusions.

- All non-medically necessary services
- All nonapproved services
- Injuries that occurred at work
- Cosmetic procedures
- Custodial care
- Dental services (unless required because of accidental injury)
- Routine vision and hearing services
- Chiropractic and naturopathic services
- Organ transplants (only limited coverage)
- Infertility treatment and services
- Routine foot care

Exclusion Periods

A medical condition that was present before the effective date of coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day, is known as a pre-existing condition. Such conditions will not be covered by HIPUtah for the first six months following the effective date of coverage except when any of the following apply to an individual:

- HIPAA eligible; or
- Transferring from an out-of-state high-risk pool within established time regulations; or
- Involuntarily terminated from either individual or group coverage and has no other option for coverage.

HIPUtah will not cover services for a pre-existing pregnancy for the first ten months following the effective date of coverage, unless the enrollee is HIPAA eligible.

Application Instructions

Enclosed in this packet is the application for coverage under HIPUtah. Please complete this form and submit it along with copies of medical records and proof of former insurance to the following address: HIPUtah P.O. Box 30192, Salt Lake City, Utah 84130-0192. For questions please call **801-442-6660** (Salt Lake area) or **800-705-9173.**

PLEASE NOTE THE FOLLOWING:

- All applicants must submit medical records or a doctor's letter showing diagnosis and prognosis of medical condition(s). Applicants are responsible for obtaining medical records and paying for any costs incurred.
- Provide documentation of prior creditable coverage by submitting copies of any insurance letters or other applicable information showing any previous insurance coverage for the last 18 months and an expiration date.
- If you are coming off 18 months of prior group coverage, including exhausting COBRA or a state continuation plan, you have 63 days to apply for continuous coverage. If you are coming off individual insurance and have been involuntarily terminated, you have 63 days to apply for continuous coverage.
- Before you allow your current health insurance coverage to lapse, contact a HIPUtah representative at 801-442-6660 (Salt Lake area) or 800-705-9173.

All information must be provided. If there is information missing on the application or if required medical records are missing, your application will be returned to you. Please check the completeness of your application before mailing. Please do not include a premium payment. You will be notified by mail whether or not you have been accepted. Once you have been accepted, HIPUtah requires that you meet with a HIPUtah representative to complete the final enrollment steps.

How to Apply for Coverage

To apply for coverage under HIPUtah, each applicant must submit a completed application and medical records. All information on the application and attachments will be reviewed and relied upon by the HIPUtah administrator for issuance of HIPUtah coverage. Once accepted and before coverage can become effective, the applicant must meet with a HIPUtah representative within 90 days to complete the final enrollment steps, unless HIPAA eligible. Coverage will not be effective until this meeting is held, approval is given, and a HIPUtah Enrollee Agreement and ID Card have been issued.

FOLLOW THESE STEPS TO APPLY FOR HIPUTAH COVERAGE:

Step 1 – Complete the application. Please be sure to answer **ALL** questions and provide accurate information.

Step 2 – Submit documentation of creditable coverage (prior health insurance coverage) if applicable.

Step 3 – Select a doctor. HIPUtah providers are listed at **www.selecthealth.org**.

Step 4 – Select a deductible and payment plan option.

Step 5 – Submit a copy of the your medical records obtained by you from your physician.

Step 6 – Submit the completed application plus any additional documentation to the HIPUtah administrator.

Applicants are urged to contact the HIPUtah administrator at **801-442-6660** (Salt Lake area) or **800-705-9173** for more information about coverage, the application process, and all other requirements necessary to obtain coverage through HIPUtah.

Enrollee Responsibilities

To ensure that continued coverage under HIPUtah is appropriate and to ensure that HIPUtah coverage is provided appropriately for covered services, enrollees are responsible for the following:

- Verifying that prenotification or precertification has been provided before services are received;
- Notifying the administrator within 72 hours after the receipt of emergency services when outside of Utah;
- Paying all premiums due on or before the due date;
- Notifying the administrator at the time the enrollee becomes covered by or eligible for Medicaid or Medicare; and
- Notifying the administrator at the time the enrollee becomes covered by or eligible for any health plan other than HIPUtah.

In addition, we encourage the enrollees to coordinate all care with his or her participating physician.

RENEWAL OR TERMINATION OF COVERAGE

Coverage under HIPUtah is provided on a month-to-month basis.

HIPUtah Monthly Premiums

(EFFECTIVE JULY 1, 2007)

HIPUtah is required by Utah law to evaluate premium rates each year for an effective date of January 1 and/or July 1.

Premiums for HIPUtah coverage are calculated based on age and deductible options. The premiums are listed in the following table. Premium increases due to an age category change are effective the first of the month following the birth date.

	OPTION 1 $500 DEDUCTIBLE $2,000 OOP*	OPTION 2 $1,000 DEDUCTIBLE $3,000 OOP*	OPTION 3 $2,500 DEDUCTIBLE $6,000 OOP*	OPTION 4 $5,000 DEDUCTIBLE $5,000 OOP*#
Age				
Under 21	$293	$255	$196	$143
21 to 25	$315	$274	$211	$153
26 to 30	$364	$317	$244	$177
31 to 35	$429	$373	$289	$210
36 to 40	$456	$398	$306	$223
41 to 45	$488	$415	$319	$231
46 to 50	$569	$483	$372	$269
51 to 55	$644	$547	$421	$305
56 to 60	$756	$648	$499	$382
61 to 64	$834	$707	$545	$428

*Medical Out-of-Pocket Maximum
#Health Savings Account Eligible Plan

HIPUTAH MEMBER PAYMENT SUMMARY

The HIPUtah Member Payment Summary is listed on the following pages. It shows the benefits and covered services for the HIPUtah plans.

NOTES:

- The deductible must be met before coinsurance applies.
- Benefit limitations may be applicable to certain services.

4646 West Lake Park Boulevard
Salt Lake City, UT 84120-8212
801-442-6660
www.selecthealth.org

HIPUtah
Utah Comprehensive Health Insurance Pool

HIPUtah New Enrollee Application Form

Please use dark ink and print legibly. Do not write in shaded areas

Administered by SelectHealth

A. COVERAGE AND PAYMENT INFORMATION

Coverage

Select one deductible/out-of-pocket

- ❑ $500 Deductible/$2,000 Out-of-Pocket Maximum
- ❑ $1,000 Deductible/$3,000 Out-of-Pocket Maximum
- ❑ $2,500 Deductible/$6,000 Out-of-Pocket Maximum
- ❑ $5,000 Deductible (HDHP)/$5,000 Out-of-Pocket Maximum

Payment Option

- ❑ Direct Monthly Billing ($5.00 monthly service fee applies)
- ❑ Preauthorized Banking Withdrawal
- ❑ Online Billing and Payment (See Payment Selection Form)

Desired Effective Date _____

B. APPLICANT INFORMATION

Note: Every person applying for a HIPUtah policy must complete a separate application, including members of the same family.

Applicant

Last Name _____ First Name _____ Middle Initial _____

Social Security# _____ Birthdate _____ Sex ❑ M ❑ F

Street Address _____ Unit# _____

City _____ State _____ ZIP _____

E-mail Address _____ Home Ph# (____) _____ Work Ph# (____) _____

Employer _____ Employer's Medical Insurance _____ Occupation _____

# of People in Household _____

Total Annual Income of All Members of Applicant's Household* $_____

Defined as the sum of adjusted gross income from federal tax return for most recent year for all members of applicant's household. Documentation may be requested by HIPUtah to verify household income and **is required on application.*

Primary Care Physician Full Name _____ Street Address _____

Responsible Party (to be completed when applicant is a minor under age 16 or lacks the legal ability to contract)

Last Name _____ First Name _____ Middle Initial _____

Street Address _____ Unit# _____

City _____ State _____ ZIP _____

Social Security# _____-____-_____ Birthdate _____ Relationship to Applicant_____

Employer _____ Employer's Medical Insurance _____Occupation _____

C. PRIOR HIPUTAH COVERAGE

Has applicant ever been covered by the HIPUtah program before? ❑ Yes ❑ No

If yes, date coverage terminated _____ Reason for Termination _____

Was the lifetime policy maximum met? ❑ Yes ❑ No

Has the applicant had coverage similar to HIPUtah in another state's uninsurable risk pool? ❑ Yes ❑ No

If yes: State _____ Plan Ph# (_____) _____ Dates of Coverage _____ to _____

Was the policy dollar maximum of the above coverage met? ❑ Yes ❑ No

Reason for Termination _____

SELECTHEALTH USE ONLY

Conditional Eligibility _____ **Premium $** _____ **Class#** _____

Effective Date _____ **Points** _____ **HIPAA Eligible** _____

Final Status Code _____ **PEC** _____

D. ELIGIBILITY REQUIREMENTS

1. **Is the applicant a resident of Utah?** ❑ **Yes** ❑ **No**
   If "Yes," how long has he or she been a continuous Utah resident? _____ years _____ months

2. **Is the responsible party a resident of Utah?** ❑ **Yes** ❑ **No**
   If "Yes," how long has he or she been a continuous Utah resident? _____ years _____ months

3. **Is the applicant currently covered by or eligible for Medicare?** ❑ **Yes** ❑ **No**
   If "Yes," Medicare number _____ Effective date _____

4. **Is the applicant currently covered by or eligible for Medicaid?** ❑ **Yes** ❑ **No**
   If "Yes," Medicaid number _____ Effective date _____

5. **Is the applicant currently covered by or eligible for any other public health plan?** ❑ **Yes** ❑ **No**
   If "Yes," program name _____ Effective date _____

6. **Is the applicant currently covered by or eligible any health insurance? (Including employer-sponsored, state extension, COBRA, or group conversion)** ❑ **Yes** ❑ **No**
   If "Yes," health insurance carrier name _____ Effective date _____

7. **If enrolled, would any employer reimburse or pay for any portion of this plan?** ❑ **Yes** ❑ **No**

8. **Has the applicant either voluntarily cancelled health insurance coverage or been involuntarily cancelled by a health insurance company within the last six months?** ❑ **Yes** ❑ **No**
   If "Yes," please answer the following questions:
   a. Was the coverage under an employer-sponsored program? ❑ Yes ❑ No
   b. Was the coverage under COBRA or state extension? ❑ Yes ❑ No
   c. Was the COBRA or state extension coverage exhausted? ❑ Yes ❑ No
   d. Was the coverage under an individual plan? ❑ Yes ❑ No
   e. Was the coverage under a group conversion plan? ❑ Yes ❑ No
   f. Was the coverage under a government-sponsored plan (e.g. Medicare, Medicaid, etc.)? ❑ Yes ❑ No
   g. Did your employer drop insurance coverage? ❑ Yes ❑ No
   h. Were you self-employed? ❑ Yes ❑ No
   i. Did you lose employment? ❑ Yes ❑ No
   j. Other reasons for loss of coverage _____

If you answered yes to any of the above, please complete section "E".

E. PRIOR/CURRENT COVERAGE INFORMATION

Will the applicant be losing coverage within the next six months for any reason? ❑ **Yes** ❑ **No**
If "Yes," give the dates of current coverage and the reason for termination below.

PRIOR/CURRENT HEALTH INSURANCE COVERAGE INFORMATION

Please complete the following information about your health insurance coverage for the last 18 months, regardless of whether it is still in effect. If you have had coverage through more than one insurance carrier in that time, please include coverage information for each carrier. Failure to complete information on this form could result in no credit toward the pre-existing condition waiting period.

Please include a letter of Creditable Coverage (termination letter) for those policies listed below with this application. The application process will be delayed if it is not included.

The following documentation is also acceptable for submission:

- Explanation of Benefits or other correspondence that indicates coverage
- Health insurance ID card
- Medical record that indicates health coverage
- Pay stubs showing payroll deduction for health coverage
- Certificate of coverage for a group health insurance policy
- Other documentation that shows evidence of health coverage

LIST BELOW ALL CORRESPONDING INSURANCE POLICIES

	CARRIER 1	CARRIER 2	CARRIER 3
1. TYPE(S) OF COVERAGE			
Employer sponsored			
COBRA			
State extension			
Individual			
Group conversion			
Government sponsored			
2. COVERAGE EFFECTIVE DATE			
3. TERMINATION DATE			
4. INSURANCE CARRIER PH#			
5. REASON FOR COVERAGE TERMINATION (e.g., loss of job, overage dependent, COBRA expiration, employer dropped coverage, nonpayment of premiums)			

F. UNINSURABILITY INFORMATION

1. **Has the applicant been denied coverage from any other health insurance carrier?** ❑ **Yes** ❑ **No**
   If "Yes," please list the type(s) of coverage for which you have applied and the carrier(s):_____

   _____

   Date of Application _____ Date of Denial _____

2. **Is an application to any other health insurance coverage currently in process for the applicant?** ❑ **Yes** ❑ **No**
   If "Yes," please list the type(s) of coverage for which you have applied and the carrier(s):_____

   _____

3. Date of Application _____

4. **Does applicant, spouse or parent, legal guardian or other responsible party work for an employer that offers health insurance benefits?**
   If "Yes," or "Unsure," list the name, address and phone number of each employer. Also list insurance carrier name and reason Applicant is not insured on this program:

   Applicant ❑ **Yes** ❑ **No** ❑ **Unsure**_____
   Spouse ❑ **Yes** ❑ **No** ❑ **Unsure**_____
   Parent, Legal Guardian or other Responsible Party ❑ **Yes** ❑ **No** ❑ **Unsure**_____

5. **Please list all current medical condition(s) that have prevented the applicant from obtaining other health insurance.**

   _____

   _____

   _____

Note: All applicants must submit with this application copies of medical records or a physician letter documenting the above medical condition(s). Documentation must specifically show date of onset, diagnosis and prognosis of said medical condition(s). It is the applicant's responsibility to obtain these records at his or her expense.

G. AFFIRMATION

I, the applicant (or parent, legal guardian or responsible party of applicant), affirm that my foregoing answers to questions in Section A and B are complete and correct to the best of my knowledge. I understand that no coverage will be in effect until the full initial premium is paid and this application has been approved and accepted by HIPUtah.

I understand that:

- "Preexisting condition," with respect to a health benefit plan means the following: (a) a condition that was present before the effective date of coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day; (b) does not include a condition indicated by genetic information unless an actual diagnosis of the condition by a physician has been made.
- Benefits otherwise payable under the policy will be reduced by all amounts paid or payable through any other health coverage, workers compensation, motor vehicle coverage, or any state or federal law or program.
- If this application contains fraudulent or material misstatements or omissions, HIPUtah may do any or all of the following: (a) cancel the agreement as though it were never effective; (b) deny benefits under the "pre-existing condition" exclusion; or (c) take any other action available to it by law.

Any matter in dispute between you and HIPUtah may be subject to arbitration as an alternative to court action pursuant to the rules of the Utah Arbitration Act. Any decision reached by arbitration shall be binding upon both you and HIPUtah. The arbitration award may include attorney's fees, if allowed by state law, and may be entered as a judgment in any court of proper jurisdiction.

DISCLOSURE AUTHORIZATION

I authorize disclosure of medical record information about me (or about the applicant, if I am other than the Applicant) to HIPUtah if needed to (a) determine eligibility for coverage; and/or (b) process claims for benefits.

This authorization takes effect on the date received by the HIPUtah administrator and remains in effect as follows:

- For information needed to process a claim for benefits, the authorization is effective for the lifetime of the HIPUtah policy or the duration of the timely filing deadline for any claim, whichever is longer.
- For information needed to evaluate the application for coverage, the authorization will be effective for 90 days after the date received by the HIPUtah Administrator.

Signature _____ Date _____ /_____ /_____
(Applicant's signature or signature of parent, legal guardian or responsible party.)

H. AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

This authorization provides for the release of PHI to the Utah Comprehensive Health Insurance Pool (HIPUtah) through its administrator SelectHealth. Federal privacy laws require health plans to include certain provisions in any authorization for use or disclosure of medical information, other than uses or disclosures for treatment, payment, healthcare operations, and as otherwise required or expressly permitted by law. If HIPUtah or SelectHealth needs to use, disclose, or receive PHI other than for the purposes set forth herein, I understand that I may be required to sign a separate authorization.

On behalf of myself (or the applicant if I am other than the applicant), I authorize any physician, healthcare provider, hospital, insurance, or reinsurance company, or other insurance information exchange to disclose PHI including alcohol, chemical dependency, mental treatment, genetic testing, or HIV treatment to HIPUtah, SelectHealth, or its representatives. I acknowledge and understand that this information will only be used for the purpose of determining enrollment in the health plan, eligibility for benefits, or payment of claims. PHI may include claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes).

If I choose not to sign this authorization, SelectHealth on behalf of HIPUtah, may be unable to enroll me in the HIPUtah health plan or to pay claims that were incurred while I had insurance coverage with HIPUtah.

I understand that I may cancel this authorization at any time by sending a written request to SelectHealth, Inc. at P.O. Box 30192, Salt Lake City, Utah 84130-0192. Cancellation of this authorization will not affect any action HIPUtah or SelectHealth took before it received my request. If I do not revoke this authorization, it will automatically expire upon termination of my coverage with HIPUtah or 24 months from the date at right, whichever comes first.

Federal law requires HIPUtah or SelectHealth to tell me that if the party to whom HIPUtah or SelectHealth, Inc. discloses my PHI shares it with anyone else, some state and federal laws may no longer protect it. This excludes alcohol and drug abuse records, which are subject to federal confidentiality rules (42 CFR part 2). Federal law prohibits redisclosure of such information without specific written authorization.

NAME _____
(Please Print)

SIGNATURE* _____ DATE _____

NAME _____
(Please Print)

SIGNATURE* _____ DATE _____

* If signed by a Personal Representative of the member/enrollee, please complete the following:

Personal Representative's Name _____

Relationship to Individual ❑Parent ❑Legal Guardian** ❑Holder of Power of Attorney**

** Please attach legal documentation if you are the Legal Guardian or Holder of Power of Attorney.

THIS AUTHORIZATION MAY NOT BE USED FOR PSYCHOTHERAPY NOTES

(PSYCHOTHERAPY NOTES are notes recorded and separately maintained by a mental health professional documenting or analyzing the contents of conversation during a counseling session.)

I. PRODUCER INFORMATION

Producer Name (Last, First, Initial) _____ Social Security# _____
Insurance License# _____ Ph# (_____) _____
Street Address _____ City _____ State _____ ZIP _____

PO Box 30192
Salt Lake City, UT 84120-0192
801-442-4350 #1/800-442-3125 #4
www.selecthealth.org

HIPUtah
Utah Comprehensive Health Insurance Pool

HIPUtah Payment Selection Form

Applicant's Name _____ **Applicant's Social Security# OR Subscriber ID** _____
(internal use only)

A. PAYMENT SELECTION

Please select one of the three available methods of payment for your monthly premium. **Your employer cannot** pay any portion of your premium, either directly or through reimbursement. Submit only personal account information.

❑ **Preauthorized Banking Withdrawal**	❑ **Online Billing and Payment**	❑ **Monthly Statement**
Complete section "B"	Complete section "C". You must include a check for the first month's premium	$5 Monthly service fee required
	You will receive a premium notice by mail once you are accepted	

B. PREAUTHORIZED BANKING WITHDRAWAL

If you select this method of payment for your monthly premium, your payment will automatically be deducted from your checking/ savings account each month. Please complete the information below.

I authorize SelectHealth to initiate debit entries to my (our) ❑ **Checking Account** ❑ **Savings Account**

Account Holder's Name _____ **Account#** _____

Financial Institution _____ **Routing & Transit#** _____

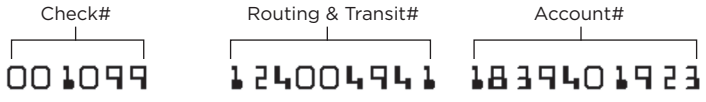
I understand that debit entries will be submitted to my account on or about the 10th of each month, regardless of the policy effective date. I understand that a **$25.00 service charge** will be assessed if the premium amount cannot be deducted from my account for any reason.

Account Holder's Signature _____ **Date** _____

PREAUTHORIZED BANKING WITHDRAWAL

Attach a Voided Check Here

Do not use a checking deposit slip for checking withdrawal.
Checking deposit slips do not always contain the necessary routing and transit information.



C. ONLINE BILLING AND PAYMENT

If you have selected the Online Billing and Payment option, complete and sign the agreement below. You will receive your monthly statement by E-mail. This E-mail will link you to a Web site where you can make your monthly payment by electronic check or by credit card.

Premium payments are due on the first day of each month.

Applicant's Name _____ **Applicant's Signature** _____

Applicant's E-mail Address _____ **Applicants Date of Birth** _____

HIPUtah
Utah Comprehensive Health Insurance Pool

Application Checkoff List

BEFORE YOU SUBMIT YOUR APPLICATION FORM, DID YOU REMEMBER TO...

- ☐ **Complete entire application**
- ☐ **Complete Section B**
  Including total annual income for all family members
- ☐ **Complete Section D, 1**
  Duration of Utah residency
- ☐ **Signatures of Applicant and Dates, Sections G and H**
- ☐ **Include:**
  Medical records or Physican letter showing diagnosis and prognosis of medical conditions

We appreciate your cooperation. Failure to complete this information may delay the review of your application and effective date of coverage with the Utah Comprehensive Health Insurance Pool (HIPUtah).

MEMBER PAYMENT SUMMARY — HIPUtah (COMBO — 80/20) 07/01/07

HIPUtah
Utah Comprehensive Health Insurance Pool

ADMINISTERED BY selecthealth℠

	PARTICIPATING (IN-NETWORK) You must use participating providers (except for emergencies).	
CONDITIONS and LIMITATIONS		
Lifetime Maximum Plan Payment — Per Person	$1,500,000	
Annual Maximum Plan Payment — Per Person	$300,000	
Pre-Existing Conditions (PEC) and Limitations[1]	Not covered for first 6 months	
Maternity Pre-Existing Conditions (PEC) and Limitations[1]	Not covered for first 10 months	
MEDICAL DEDUCTIBLE and MEDICAL OUT-OF-POCKET	**You Pay**	
Calendar Year Deductible and Out-of-Pocket Amounts		
Deductible is included in the out-of-pocket maximum	Deductible	Out-of-Pocket
$500 Deductible	$500	$2,000
$1,000 Deductible	$1,000	$3,000
$2,500 Deductible	$2,500	$6,000
INPATIENT SERVICES	**You Pay**	
Medical, Surgical, Hospice, and Emergency Admissions *Semi-private room, board, anesthesia, and all related services*	20% after deductible	
Maternity *Includes all related maternity services after calendar year deductible. Enroll in the SelectHealth Healthy Beginnings℠ program: 866-442-5052*	20% after deductible	
Skilled Nursing Facility *Up to 30 days/calendar year*	20% after deductible	
Rehab Therapy: Physical, Speech, Occupational *Up to 30 days/calendar year for all therapy types combined*	20% after deductible	
PROFESSIONAL SERVICES	**You Pay**	
Office Visits and Office Surgeries		
Primary Care Provider (PCP)[2]	20% after deductible	
Secondary Care Provider (SCP)[2]	20% after deductible	
Preventive Care Office Visits	See office visits	
Adult and Pediatric Immunizations	Covered at 100%	
Elective Immunizations	20%	
Allergy Tests	See office visits	
Allergy Treatment and Serum	20% after deductible	
Physician's Fees — *Medical, Surgical, Anesthesia*	20% after deductible	
OUTPATIENT SERVICES	**You Pay**	
Outpatient and Ambulatory Surgical Facility — *Includes all related facility services*	20% after deductible	
Ambulance (Air) — *emergencies only*	20% after deductible	
Ambulance — *emergencies and urgent conditions only*	20% after deductible	
Emergency Room Participating Facility *Includes all facility services rendered in conjunction with the ER*	20% after deductible	
Emergency Room Nonparticipating Facility *Includes all facility services rendered in conjunction with the ER*	20% after deductible	
Intermountain InstaCare℠ Facilities, Urgent Care Facilities	20% after deductible	
Intermountain KidsCare℠ Facilities	20% after deductible	
Intermountain ExpressCare℠ Facilities	20% after deductible	
Chemotherapy, Radiation, and Dialysis	20% after deductible	
Diagnostic Tests, Minor	20% after deductible	
Diagnostic Tests, Major[1]	20% after deductible	
Home Health, Hospice	20% after deductible	
Outpatient Rehab Therapy: Physical, Speech, Occupational *Up to 20 visits/calendar year for each therapy type*	20% after deductible	

See next page for additional benefits and footnotes.

MISCELLANEOUS SERVICES	You Pay
Chiropractic Care	Not covered
Durable Medical Equipment (DME)	20% after deductible
Infertility	Not covered
Injectable Drugs and Specialty Medications	20% after deductible[3]
Mental Health and Chemical Dependency	
Inpatient — Up to 10 days/calendar year	20% after deductible
Outpatient — Up to 20 visits/calendar year	20% after deductible
Miscellaneous Medical Supplies	20% after deductible

PRESCRIPTION DRUGS	You Pay
If your medical deductible is:	$500 $1,000 $2,500
Your Rx deductible per person/calendar year is:	$150 $250 $500
The Rx Deductible does not apply to medical out-of-pocket amounts	
Tier 1	$5 after Rx deductible[3]
Tier 2	25% after Rx deductible[3]
Tier 3	50% after Rx deductible[3]
Up to a 30-day supply for covered medications; generic substitution required. Same copay/coinsurance applies for each 30-day supply when obtained using your 90-day Maintenance Drug Benefit (Medco by Mail or Retail90℠)	

FOOTNOTES

1. Refer to the Enrollee Agreement for more information.
2. Refer to your HIPUtah Provider & Facility Directory to identify whether a provider is a Primary Care or Secondary Care Provider.
3. Preauthorization is required on certain injectable and prescription drugs. If you fail to preauthorize, the drug will not be covered. Please refer to your Enrollee Agreement for more information.

All deductible/copay/coinsurance amounts are based on eligible charges and not on the provider's billed charges. You are responsible to pay for excess charges on covered services from nonparticipating providers and facilities. Excess charges are not applied to the out-of-pocket maximum. Refer to your Enrollee Agreement or Provider & Facility Directory for more information.

MEMBER PAYMENT SUMMARY — HIPUtah (HDHP 5000) 07/01/07

HIPUtah
Utah Comprehensive Health Insurance Pool

ADMINISTERED BY selecthealth℠

	PARTICIPATING (IN-NETWORK)	
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Lifetime Maximum Plan Payment — Per Person	$1,500,000	
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Pre-Existing Conditions (PEC) and Limitations[1]	Not covered for first 6 months	
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DEDUCTIBLE and OUT-OF-POCKET	**You Pay**	
Calendar Year Deductible and Out-of-Pocket Amounts	Deductible	Out-of-Pocket
Deductible is included in the out-of-pocket maximum	$5,000	$5,000
INPATIENT SERVICES	**Covered**	
Medical, Surgical, Hospice, and Emergency Admissions *Semi-private room, board, anesthesia, and all related services*	100% after deductible	
Maternity *Includes all related maternity services after calendar year deductible. Enroll in the SelectHealth Healthy Beginnings℠ program: 866-442-5052*	100% after deductible	
Skilled Nursing Facility *Up to 30 days/calendar year*	100% after deductible	
Rehab Therapy: Physical, Speech, Occupational *Up to 30 days/calendar year for all therapy types combined*	100% after deductible	
PROFESSIONAL SERVICES	**Covered**	
Office Visits and Office Surgeries		
Primary Care Provider (PCP)[2]	100% after deductible	
Secondary Care Provider (SCP)[2]	100% after deductible	
Preventive Care Office Visits	Covered at 100%	
Adult and Pediatric Immunizations	Covered at 100%	
Elective Immunizations	Covered at 100%	
Allergy Tests	See office visits	
Allergy Treatment and Serum	100% after deductible	
Physician's Fees — *Medical, Surgical, Anesthesia*	100% after deductible	
OUTPATIENT SERVICES	**Covered**	
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Ambulance (Air) — *emergencies only*	100% after deductible	
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Home Health, Hospice	100% after deductible	
Outpatient Rehab Therapy: Physical, Speech, Occupational *Up to 20 visits/calendar year for each therapy type*	100% after deductible	

See next page for additional benefits and footnotes.

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NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

I. Introduction

The Utah Comprehensive Health Insurance Pool, also known as HIPUtah, is committed to protecting the privacy of your Personal Information and is required by applicable federal and state laws to maintain the privacy of your Personal Information.

As you read this document, please keep in mind that the terms "we," "us," and "our" refer to HIPUtah.

This notice describes our legal duties and privacy practices with respect to Personal Information. When we use or disclose Personal Information, we must abide by the terms of this notice (or other notice in effect at the time of the use or disclosure).

For the purposes of this notice, we have defined the following terms:

- "Affiliated Providers" are doctors and other healthcare practitioners who are not employed by IHC Health Services but either have a contractual relationship with SelectHealth or are credentialed to admit patients to an Intermountain hospital.
- "SelectHealth" refers to SelectHealth, Inc. SelectHealth provides administrative services, such as claims processing and care management, on behalf of HIPUtah. When providing these administrative services, SelectHealth will use and disclose your Personal Information as described in this notice.
- "IHC Health Services" means the hospitals, clinics, doctor offices, and other healthcare facilities owned and operated by IHC Health Services, as well as the individuals employed by IHC Health Services at these facilities.
- "Intermountain" refers to IHC Health Services, Inc.
- "Personal Information" means your personal medical information that describes your physical or mental health or the payment for the provision of your healthcare as well as any other financial information that we may have collected about you.
- "Personal Representative" means an individual who has authority under law to make healthcare decisions on behalf of another person, e.g. a parent for a minor child.

IHC Health Services and Affiliated Providers have different privacy practices than HIPUtah. As a result, if you are a patient of IHC Health Services or an Affiliated Provider, you will receive a separate notice of their privacy practices. To request a copy of the privacy notices of IHC Health Services, please call 800-442-4845. To receive a copy of the privacy notices of Affiliated Providers, please contact those providers directly.

II. Collection of Personal Information

We may collect Personal Information from you, healthcare providers, and other payers of healthcare. We may also collect Personal Information from governmental agencies, legal proceedings, and consumer reporting agencies.

III. Uses and Disclosures With an Authorization

An authorization is a written document signed by you or your Personal Representative that gives us permission to use your Personal Information for a specific purpose. We will only use your Personal Information without an authorization in ways described in the next section of this notice: "Uses and Disclosures Permitted by Law Without an Authorization." You may revoke an authorization at any time in writing, except to the extent that we have taken an action in reliance on the use or disclosure indicated in the authorization.

IV. Uses and Disclosures Permitted by Law Without an Authorization

A. Use or Disclosure by us for payment or healthcare operations. We use Personal Information for the following routine purposes:

Payment. We use and disclose Personal Information for payment

of health coverage premiums and to determine and fulfill our responsibility to provide you benefits—for example, to make coverage determinations, administer claims, and coordinate benefits with other coverage you may have. We may also disclose Personal Information to consumer reporting agencies as part of our payment activities.

Finally, we will disclose Personal Information about an unemancipated minor to the minor's parents who have custody of that minor or their authorized representatives. We limit these disclosures to the information necessary to understand how a claim was processed. We disclose this information for the effective management of the coverage provided by HIPUtah. A minor may have the right to limit these disclosures. See the subsection "Your Right to Receive Confidential Communication" in the "Your Individual Rights" section.

Healthcare Operations. We use and disclose Personal Information for our healthcare operations, which include internal administration, planning, and various activities that improve the quality of the healthcare, for which we pay. For example, we may use your Personal Information to assess insurance rates and to evaluate how many of the children on our plans have received the recommended immunizations. We may disclose Personal Information to individuals or companies that assist with payment and healthcare operations. However, such disclosures are only made if the person or company agrees to safeguard your Personal Information.

In addition, we may disclose Personal Information as follows:

- To another healthcare entity for its healthcare operations or payment activities.
- To Affiliated Providers and IHC Health Services to improve the overall the healthcare you receive as well as to help them better manage your care. For example, SelectHealth has programs in place to manage the treatment of chronic conditions, such as diabetes or asthma. As part of these programs, we share information with Affiliated Providers and IHC Health Services to facilitate improved coordination of the care members receive for these conditions.

We may use Personal Information to identify health-related services and products that may be beneficial to your health and then contact you about these services and products. However, unless we have an authorization from you, we will not disclose Personal Information to individuals or organizations for the marketing of products or services that are not paid for or provided by HIPUtah.

Treatment. We may disclose Personal Information to healthcare providers to support them in providing treatment.

Special Protections for Certain Types of Information. We may request Personal Information for underwriting purposes. If the health insurance is not placed with us, we will not use or disclose this information for any other purpose. We may request an HIV/AIDS test for underwriting purposes, but only if we provide proper notice and follow other requirements of state law. If we do require an HIV/AIDS test, we will not release the results of this test unless we have specific written permission to do so. Additionally, we will not request private genetic information from asymptomatic individuals for underwriting purposes. However, we may request private genetic information in certain circumstances to determine our obligation to pay for healthcare services.

B. Public Health Activities. We may disclose Personal Information for the following public health activities and purposes: (1) to report health information to public health authorities for the purpose of preventing or controlling disease, injury, or disability as required by law and public health concerns; (2) to report child abuse and neglect to public health authorities or other government authorities authorized by law to receive such reports; (3) to report information about products under the jurisdiction of the U.S. Food and Drug Administration; and (4) to alert a person who may have been exposed to a communicable disease or may otherwise be at risk to contracting or spreading a disease or condition.

C. Disclosure to Relatives and Close Friends. We may use or disclose Personal Information to a family member, other relative, a close personal friend, or any other person identified by you when you are either present for or otherwise available prior to the

disclosure, if we (1) obtain your agreement; (2) provide you with the opportunity to object to the disclosure and you do not object; or (3) reasonably infer that you do not object to the disclosure.

If you are not present or the opportunity to agree or object to a use or disclosure cannot practicably be provided because of your incapacity or an emergency circumstance, we may exercise our professional judgment to determine whether a disclosure is in your best interest. If we disclose information to a family member, other relative, or a close personal friend, we would disclose only information that is directly relevant to the person's involvement with your healthcare.

D. Victims of Abuse, Neglect, or Domestic Violence. If we reasonably believe you are a victim of abuse, neglect, or domestic violence, we may disclose your Personal Information to a government authority, including a social service or protective services agency authorized by law to receive reports of such abuse, neglect, or domestic violence.

E. Health Oversight Activities. We may disclose Personal Information to a health oversight agency that oversees the healthcare system and ensures compliance with the rules of government health programs such as Medicare or Medicaid.

F. Judicial and Administrative Proceedings. We may disclose Personal Information in the course of a judicial or administrative proceeding in response to a legal order or other lawful process.

G. Law Enforcement Officials. We may disclose Personal Information to the police or other law enforcement officials as required by law or in compliance with a court order.

H. Health or Safety. We may use and disclose Personal Information to prevent or lessen a serious and imminent threat to an individual's or the public's health or safety.

I. Specialized Government Functions. We may disclose to military authorities the personal and health information of armed forces personnel under certain circumstances. We may disclose to authorized federal officials personal and health information required for lawful intelligence, counterintelligence, and other national security activities.

J. Workers' Compensation. We may disclose Personal Information as necessary to comply with workers' compensation laws.

K. Research. We may use or disclose Personal Information without your consent or authorization for purposes of research if an Institutional Review Board or Privacy Board approves a waiver of authorization for disclosure.

An Institutional Review Board or a Privacy Board is responsible for reviewing research that involves human subjects and for reviewing the effect of the research on the subjects' privacy rights. Either board must have at least one member on the board not affiliated with HIPUtah.

L. Required by Law. We may use or disclose Personal Information when the following circumstances exist:

- Such use or disclosure is required by law; and
- The use or disclosure complies with and is limited to the relevant requirements of such law.

VI. Your Individual Rights

A. For More Information or Complaint Resolution. If you would like more information about your privacy rights, are concerned that we have violated your privacy rights, or disagree with a decision that we made about access to Personal Information, you may contact SelectHealth's Privacy Office. Please see the last section of this notice, entitled "Privacy Office," for specific contact information. You may also file written complaints with the director of the Office of Civil Rights in the U.S. Department of Health and Human Services. Upon request, SelectHealth's Privacy Office will provide you with the correct address for the Office of Civil Rights. We will not take action against you if you file a complaint with the Office of Civil Rights or us.

B. Right to Request Additional Restrictions. You may request restrictions on our use and disclosure of Personal Information: (1) for payment and healthcare operations; or (2) to individuals (such as a family member, other relative, close personal friend, or any other person identified by you) involved with your care or with payment related to your care. While we will consider all requests

for additional restrictions carefully, we are not required to agree to a requested restriction.

C. Right to Inspect and Copy Your Health Information. You may request access to our records which (1) we use for decision-making purposes; and (2) contain your Personal Information, including your enrollment, payment, claims adjudication, case, medical management records, and your billing records. You may request access in order to inspect and ask for copies of the records. Under limited circumstances, we may deny you access to a portion of your records. If you request a copy or copies of your record, you will be charged a cost-based fee for each copy. If you wish to access the Personal Information maintained by an Affiliated Provider or by IHC Health Services, please contact them directly.

D. Right to Request Amendment to Your Records. You have the right to request an amendment to your Personal Information that we created and used for decision-making purposes. SelectHealth will comply with your request unless we are not the originator of the information or we believe that the information that would be amended is accurate and complete or other special circumstances apply. If you wish to amend the Personal Information maintained by an Affiliated Provider or by IHC Health Services, please contact them directly.

E. Right to Receive an Accounting of Disclosures. Upon request, you may obtain a written summary of certain disclosures of your Personal Information made by us. Your request must state a time period, which may not exceed the six years prior to the date of your request and may not include dates before April 14, 2003.

If you request an accounting more than once during a twelve month period, we will charge you a reasonable fee for each additional accounting statement.

F. Right to Receive Confidential Communications. In certain circumstances, we will agree to any reasonable request for you to receive your Personal Information by alternative means of communication or at alternative locations.

G. Right to Receive a Paper Copy of This Notice. If you have not already received one, you have the right to receive a paper copy of this notice. To request a paper copy of this notice, please contact SelectHealth's Privacy Office.

Note: Any Personal Representative of yours can exercise these rights related to your Personal Information.

VII. Maintaining the Privacy of Personal Information

We guard Personal Information by limiting access to this information to those who need it to perform assigned tasks and through physical safeguards (e.g., locked filing cabinets and password-protected computer systems).

In addition, when you or someone else acting on your behalf calls our Member Services department, the Member Services representative may need to limit the Personal Information disclosed. This is done to help safeguard your Personal Information. The representative may ask for information to verify the identity of the caller before disclosing any Personal Information. The amount and type of Personal Information that we can release depends on several factors which are outlined below:

- Who is requesting the Personal Information
- What that person's relationship is to the subject of the Personal Information
- For what purpose the Personal Information is being requested
- If the Personal Information relates to the treatment of certain conditions

We realize that these restrictions may at times seem inconvenient, but the restrictions help us maintain the privacy of your Personal Information.

VIII. Opt Outs

As part of our legal duties to protect your Personal Information, we are required to allow you to "opt out" of certain disclosures. The most common type of disclosure

that applies to "opt outs" is the disclosure of personal information to a company not affiliated with HIPUtah so that company can market its products or services to you. We don't make such disclosures, so it isn't necessary for you to complete an "opt out" form or take any action to restrict such disclosures.

IX. Effective Date and Duration of This Notice

A. Effective Date. This notice describes the privacy practices of HIPUtah as of July 1, 2005.

B. Right to Change Terms of this Notice. We may change the terms of this notice at any time. If we change this notice, we may make the new notice terms effective for all Personal Information that we maintain, including any information created or received prior to issuing the new notice. You may also obtain any notice by contacting SelectHealth's Privacy Office.

X. Privacy Office

SelectHealth answers privacy-related questions and complaints as part of the administrative services it provides to HIPUtah. You may contact SelectHealth's Privacy Office at the following address, phone number or e-mail:

4646 West Lake Park Blvd.

Salt Lake City, UT 84120

1-800-442-4845

E-mail: privacy@intermountainmail.org

Administered by

4646 West Lake Park Boulevard

Salt Lake City, Utah 84120-8212

801-442-6660/800-705-9173

www.selecthealth.org